Multi-Party Consent for Release of Information

Complies with HIPAA and 42 CFR Part 2
Source: Legal Action Center

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG AND MENTAL HEALTH INFORMATION

I, _____, authorize the following agents:
(Name of patient)

1) _____
(Name of Primary Care Physician or OB/GYN and staff)

2) _____
(Name of CSTAR Treatment Program)

3) _____
(Name of MO HealthNet Managed Care health plan)

4) _____
(Name of Managed Care Behavioral Health Organization)

5) Missouri Department of Alcohol and Drug Abuse

6) MO HealthNet Division

to communicate with and disclose to one another the following information [initial each category that applies]:

____ my name and other personal identifying information;

____ my status as a patient in alcohol or drug treatment;

____ initial and subsequent evaluations of my service needs;

____ summaries of alcohol/drug and mental health assessment results and history;

____ summary of alcohol/drug treatment and mental health services plan(s), progress and compliance;

____ attendance in alcohol/drug treatment and mental health services;

____ discharge plan(s) for alcohol/drug treatment and mental health services;

____ date of discharge from alcohol/drug treatment and mental health services, and discharge status:

____ other:_____

The purpose of the disclosures authorized in this consent is to *enable the above parties to evaluate my need for services and to provide and coordinate those services.*

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health services I receive are protected by federal law under HIPAA.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(1) One month following the date I stop receiving services from the alcohol and drug treatment program,

OR

(2) _____
[Specify date if desired]

I understand that generally the alcohol and drug treatment may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated:_____ _____
Signature of member

Dated: _____ _____
Signature of witness